

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/10/2009
NAME OF PROVIDER OR SUPPLIER BROWNWAY RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 328 SCHOOL STREET ENOSBURG FALLS, VT 05450		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite complaint investigation was initiated by the Division of Licensing and Protection on 1/20/09, and concluded on 2/10/09. The following deficiencies were cited as a result:	R100	3/04/09 per telephone call with Tanya Gervais, MGR Addendum: FEB 27 2009	
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to conduct a significant change in status assessment for one resident (Resident #1). Findings include: 1. Per record review, Resident #1, who is cognitively impaired, eloped from the facility on the night of 12/28/08. Per interview with family members, attempting to elope was a new behavior for this resident and required interventions to assure safety. The current assessment written 9/20/08 listed the resident as not having wandering/elopement behaviors, and was not updated to reflect current behavior status after the elopement. Per interview on 1/20/09 at 3:00 PM, the manager confirmed that a significant change in status assessment had not been initiated.	R136	A review of all resident's care plans and assessments was made to assure they were up to date. Nursing was reeducated on the importance of timely annual + significant change assessments. * A significant change assessment was completed on 1/22/09. (for Resident #1) The nursing staff + mgr. will continue to monitor completion on a timely basis. Manager will be responsible for monitoring. POC accepted 3/04/09 w/ addendum Karen Campos, RN	1/22/09
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES	R145		

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

681F11

Tanya Gervais
TITLE mgr.

(X6) DATE

2/26/09

If continuation sheet 1 of 2

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/10/2009
NAME OF PROVIDER OR SUPPLIER BROWNWAY RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 328 SCHOOL STREET ENOSBURG FALLS, VT 05450		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R145	Continued From page 1 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assure that a plan of care was developed by a nurse based on the abilities and needs identified in the resident assessment for one resident (Resident #1). Findings include: 1. Per record review, the facility failed to develop a written plan of care for Resident #1 who was admitted to the facility in September 2008. The resident is cognitively impaired, and needs cueing assistance for dressing, eating, and hygiene, as well as one assist for bathing. The resident also required nursing oversight/monitoring for medical problems. Per interview on 1/20/09 at 3:00 PM, the manager confirmed that the nurse did not oversee the development of a care plan to describe the care and services provided to this resident.	R145	3/04/09 Addendum Per telephone call w/ Tanya Gervais MGR All resident care plans were reviewed. Nursing staff was reeducated on timeliness of care plans, and updating them as needed. 1/24/09 * A written plan of care was completed prior to inspector's departure on 1/24/09. (for Resident #1) * The nursing staff and mgr. will continue to monitor completion on a timely basis. Manager is responsible for monitoring. P.O.C. accepted w/addendum 3/04/09 Karen Campos, RN	